

TESTIMONY FOR THE SUBCOMMITTEE ON THE FEDERAL WORKFORCE AND AGENCY ORGANIZATION

Mr. Chairman, Ranking Member Davis and distinguished members of the Subcommittee. Thank you for allowing MEDecision, Inc., to submit a formal statement for the record on the extremely important topic of using information technology to improve healthcare. I am David St.Clair, Founder and CEO of MEDecision, Inc. the recognized market leader in collaborative care management solutions for the health insurance industry. Our clinical systems are used by more than 60 payer organizations around the country to help coordinate care for about one in every six insured people, including sizeable numbers of federal employees and their families.

We commend this Subcommittee's commitment to drive reform in the healthcare industry through the development, standardization and interoperability of health information technology. For seventeen years, MEDecision has been leading the effort to create clinical information technology both to improve the quality of healthcare and to lower its cost, thus expanding its affordability. In that regard, we believe it necessary to focus on providing data-rich health care records for each individual that can be used by them and by their providers and managers of care to improve outcomes while reducing costs to the overall system.

The core of today's efforts is the electronic health record. In general, the EHR is most valuable today for the sickest members of our society – the 10% of the population that consumes 80% of the cost. With multiple conditions requiring multiple specialists, many powerful medications, numerous ancillary care providers and careful care coordination from case and disease managers, these individuals are also likely to be the least able personally to communicate the complexity of their histories and health status to their next treating physician. Yet it's exactly that complexity that confounds the medical community's attempts to reduce errors of omission and commission and to minimize the cost of duplicative and otherwise unnecessary care. Fortunately, however, the cost savings potentially available from resolving the health care information deficit by using the payer-based health record (PBHR) and the individual health record (IHR) for the sickest patients in our country will likely pay for the national health information network infrastructure used by the entire population.

Sources of Healthcare Information

Broadly speaking, there are three sources of health care information about patients: the patients themselves (or their care givers); the patients' physicians, hospitals and other providers; and the patients' health plan or other payer.

Most patients have only limited information about their own care and even less ability to obtain, retain and store such data. Worse, a patient's ability to personally maintain their own health record decreases with illness, infirmity and, often, with age. Even the most user-friendly personal health record (PHR) systems available today are seldom used and even less frequently updated on a timely basis by their owners.

Physicians, hospitals and other providers are required by law and professional ethics to maintain significant records pertaining to the care they provide. These providers do not either generally or comprehensively obtain patient data from the spectrum of other providers. Thus, hospitals might have a deep reservoir of information regarding the services and tests provided to patients within the facility and, perhaps, by the admitting physician, but little, if any, information from other facilities or physicians who have treated those same patients. A single physician knows and has records of everything the patient has told him and the treatment he has provided, but that provider knows neither what the patient has been told by other physicians nor what treatment other physicians have provided. Complicating the distributed nature of the information is that it remains overwhelmingly paper-based and hand-written, rendering it exceedingly difficult to integrate, analyze and/or transmit effectively.

Today, payers have the electronic data from which to construct the broadest picture available of an individual's history across the continuum of care. The health plans know what they have gathered through care management functions and what they have paid in the past through claims. These data cross all provider types – doctors, hospitals, laboratories, pharmacies and so on. In addition, payers increasingly have access to detailed laboratory results for their beneficiaries and remote monitoring data from patients in their disease management programs.

Payer-based Health Records and the Patient Clinical Summary

Today, health plans are beginning to offer their collected information, generically called a payer-based health record, to both physicians and patients as the basis for discussions about what actions would likely best serve the patient's clinical and behavioral needs.

MEDecision has developed a payer-based health record known as the Patient Clinical Summary (PCS) (a copy is attached to my remarks). The PCS chronicles an individual patient's comprehensive health plan record, including every medical treatment, lab test, medication and related service that has been paid for by the individual's health plan. This summary can include a patient's demographic profile, health status measure, medical conditions, inpatient and emergency room admissions, monitored services, specialist visits and treatment options.

Providers depend on a reasonably complete health care picture of a patient to make important medical decisions. Unfortunately, they are often unable to get complete and accurate information quickly enough to determine the best course of care to obtain the best outcome. There is no better example than in an emergency room in which patients often arrive unconscious and unaccompanied to be treated by physicians who have little and often no knowledge of the patient's existing medical conditions, whether they are taking medication, or their degree of susceptibility to allergic reactions. In such instances, physicians have the greatest need for patient data yet are least likely to be able to obtain it.

In every emergency room in the country, physicians attempt to obtain medical information about arriving patients by interviewing them if they are conscious, inquiring about their history from family members or from the ER's own computerized records should the prospective patient have been treated there previously. An ER's internal electronic record system is often the sole means of obtaining patient data for patients arriving unconscious and alone.

PCS Improving Healthcare Today

Being tested today between a health benefits company and a major health system, the PCS analyzes and summarizes patient health records for immediate application by attending physicians. Health plan member data and clinical best practices information is made immediately available when and where physicians need it most, at the point patients are about to be treated.

Initial tests of the program indicate electronic transmission of the PCS to emergency room physicians lowers ER patient treatment costs. Anecdotal experience indicates that approximately 7.5% of high-acuity patients seen in the ER would not be admitted if attending physicians had immediate access to the data in the PCS. At a typical ER admission cost of approximately \$8,000 per patient, millions of dollars could be saved annually as a result.

The Advent of the Individual Health Record

This fall, MEDecision and one of the innovative vendors of PHR software, will release what we believe will be the first individual health record capability in production. The IHR will be available to a test population of health plan members enrolled in a disease management program and will be pre-populated and updated by the individual's PBHR. The IHR concept, supported by America's Health Insurance Plans and many other organizations, allows us to combine the data collected continuously by the payers with the information collected directly from patients and their family. This enhanced record, when thoroughly

processed by our clinical analytics and combined with information on clinical best-practice to create the PCS, becomes an even more powerful tool for use by the patient, their physicians and their care manager. The advantage of the IHR over either the PHR or the PBHR by themselves is that it can include information not normally known by payers, like allergies and family history, but also can be used for patients who either can not or simply do not build or update their records themselves. It also can readily offer portability of information should the patient choose to change health plans.

Federal Employee Health Benefit Plan

As you know, the Office of Personnel Management (OPM) in its Carrier Letter for the coming benefit year asked for several health information technology improvements from the FEHBP carriers. While OPM did not specifically mandate the implementation of a payer-based health record, the PCS could be a major step to resolve many of OPM's concerns. We believe that the federal workforce and their families, as well as the 280 million citizens they serve, would benefit greatly from the implementation of a payer-based health record. We believe that the Patient Clinical Summary, or something like it, ought to be adopted by OPM and by every other Federal agency that purchases health coverage. There is no better or more cost effective way to get vital patient health data directly to care providers today, the result of which will be improved patient care, lower costs and the wider availability of affordable health care for all. And, of course, all citizens benefit from the better health and increased productivity of federal workers.

Low Cost of PCS Implementation

One of the hurdles most commentators raise for adoption of electronic health records is the cost of implementation for providers. While few dispute the value of providing health care professionals with comprehensive patient health information and diagnostic aids electronically and in real time, as members of the Subcommittee are well aware, many obstacles exist to improving patient outcomes and reducing health care costs via electronic record exchange. Beyond the cultural reluctance of some to adopt electronic patient health records, cost is usually the number one impediment, followed closely by an alleged need for new and possibly untested technology.

It is our experience that cost and lack of technological innovation need not be an impediment to the quick and cost effective electronic availability of patient health records. In fact, to make patient medical records available to as many care providers as possible, we have purposively committed ourselves to a low-cost, low-tech, incremental approach to electronic health record delivery. By starting with the environments whose patients are highest cost and at highest risk, we can use the early quality of care improvements and savings to build trust, momentum and the business case for subsequent levels of investment and effort.

To implement the PCS, a hospital or doctor's office need not make an investment beyond a PC and an Internet connection to receive a printable PDF file containing a patient's PBHR or IHR. Preliminary data indicate the IHR program cost at between 50 cents and \$1.00 per health plan member per month. For far less than 1% of the cost of health insurance, plan members can immediately benefit from their medical records being electronically accessible to all qualified and authorized health care providers in complete and total compliance with HIPAA privacy requirements and consistent with state laws.

Interface with Other Systems

Mr. Chairman, as you know, last week The Centers for Medicare and Medicaid Services (CMS) announced that it would give to physicians, at no cost, the electronic medical record (EMR) system currently used by the Veteran's administration, the VistA program. But VistA is only one of many EMR systems on the market, so interoperability is key to the future of the use of the PCS in the provider community as it is in the PHR market. MEDecision is taking a leadership role in helping to define standardized transactions for use with the current major vendors. While these standards will likely be modified or replaced by the eventual emergence of true national standards embraced by every vendor, value can be created for all parties in the short term by linking the most widely-used EMRs with the PBHR or IHR being offered by the regionally-dominant payers.

This early demonstration of the value of clinical data exchange will help fuel the further development of the peer-to-peer networks envisioned by ONCHIT and many in the healthcare information technology industry.

Coordination with ONCHIT

Mr. Chairman, the evolution in health care information has, we believe, finally reached a tipping point. While the Office of the National Coordinator of Health Information Technology tackles the essential tasks of developing a National Health Information Network Architecture and standards for interoperability, we can provide the critical first step which will demonstrate the value of such information at the point of care, with relatively little cost to consumers, providers or the system. In fact, the early indications demonstrate that the savings from the emergency room alone may cover the entire cost of the PCS infrastructure.

Making PCS available to physicians and other care providers at the point of care can facilitate the development of the National Health Information Network and the goal of electronic integration of all medical records. Delivered through one of the first connections to a peer-to-peer Regional Health Information Network (RHIN), a standards-based PCS can guarantee early adopters of appropriate EMRs that significant data will be available from the RHIN for their use, driving adoption far more quickly than if we had to wait for patient data to accumulate in the new systems. Payer data will continue to be of special value, of course, during the extended period before all care is delivered by providers with compliant EMRs.

The PCS is the first step that will help pave the road to full interoperability. This will improve the quality of care delivery and provide consumers the knowledge they need to really control their health care decisions regardless of whatever health care plan they choose

Given the capability of existing technology to provide physicians and other care providers with such a range of meaningful and relevant information, and given the fact that such information is already routinely gathered by existing health plans throughout the nation, we at MEDecision urge both the federal and state governments to support the meaningful exchange of this clinical information from health plans to patients and care providers. The result will be improved patient care, lower healthcare costs and more affordable healthcare for all.

Mr. Chairman and Ranking Member Davis, the commitment of this subcommittee, of Representatives Murphy and Kennedy, and, of course, of the President will help yield the greatest benefit of all: better health for our citizens. We at MEDecision are proud to be part of that process. We look forward to working with you, the subcommittee, Congress, OPM and ONCHIT to develop a healthier future for all Americans.

Thank you again, Mr. Chairman and Ranking Member Davis for the opportunity to appear before this Subcommittee. I am prepared to answer any questions you may have.